

San Diego's 23<sup>rd</sup> People First Self-Advocacy Conference  
"San Diego People First – Then, Now and Forever"  
MAY 11 & 12, 2013

**REGISTRATION FORM**

PLEASE PRINT YOUR INFORMATION CLEARLY.  
**ONE REGISTRATION FORM FOR EACH PERSON ATTENDING THE CONFERENCE**  
**INCLUDING ATTENDANTS & CARE PROVIDERS.**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

Please check: \_\_\_\_\_ Consumer \_\_\_\_\_ Parent \_\_\_\_\_ Attendant/Staff \_\_\_\_\_ Other

ADA ACCOMMODATIONS NEEDED: \_\_\_\_\_

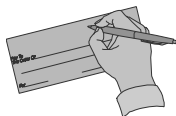
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*Is this your first time attending the SDPF Self-Advocacy Conference? We will have mentors and orientation resources available for self-advocates who are new to the conference.*

Please check **ONLY ONE**:

- \_\_\_\_\_ Own Room  
\_\_\_\_\_ Two people in room  
\_\_\_\_\_ Three people in room  
\_\_\_\_\_ Four people in room  
\_\_\_\_\_ Saturday only (NO ROOM)  
\_\_\_\_\_ Both days (NO ROOM)

| <b><i>San Diego/ Imperial County Resident</i></b> | <b><i>Out of County Resident</i></b> |
|---|--------------------------------------|
| \$ 225  | \$ 250                               |
| \$ 160 EACH Person                                | \$ 190 EACH Person                   |
| \$ 135 EACH Person                                | \$ 170 EACH Person                   |
| \$ 125 EACH Person                                | \$ 160 EACH Person                   |
| \$ 75   | \$ 100                               |
| \$ 95   | \$ 120                               |



**MAKE CHECKS PAYABLE TO: UCP (United Cerebral Palsy)**

& mail WITH THIS FORM to:

**San Diego Self-Advocacy Conference**  
8525 Gibbs Drive, Suite 209, San Diego, 92123  
**Vendor #: PM0859**

**\*Roommate Request:** You **MUST** list your roommate on your registration form. We cannot find a roommate for you! Talk to your friends and see if they are planning to go or ask your resource counselor or service coordinator for suggestions. **IF YOU LEAVE THIS BLANK, YOUR REGISTRATION WILL NOT BE PROCESSED.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

If you have questions, call Carmel at **(858) 571-7803 x 118** or Laura at **(858) 278-5420 x 132**  
between 8 a.m. & 4 p.m., Monday – Friday

**REGISTRATION FORMS AND PAYMENT ARE DUE BY APRIL 12, 2013.**

A confirmation letter with additional information will be sent. ***No refunds after April 26, 2013.***

**YOU MUST COMPLETE THE OTHER SIDE OF THIS REGISTRATION FORM!**

**CONFERENCE REGISTRATION FORM – SIDE B**  
**Medical and Support Needs Information for Participants**

**PLEASE READ AND THEN COMPLETE THIS FORM!**

● We need the following information for your personal safety. The information provided below will be folded into the name badge holder of each participant for ready access in the event of an emergency. United Cerebral Palsy is not liable for supervision, medical, or personal care needs and provides this service as a courtesy.

● All **SUPERVISION, MEDICAL and PERSONAL CARE** needs are the responsibility of each conference participant. A support person **MUST** accompany individuals needing **SPECIAL ASSISTANCE** or **SUPERVISION**.

● PLEASE REMEMBER THAT **ALL SUPPORT PEOPLE ARE REQUIRED TO PAY REGISTRATION FEES AND SUBMIT A SEPARATE REGISTRATION FORM** FOR THEIR ATTENDANCE AT THE CONFERENCE.

**YOUR NAME (Conference Participant):** \_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_

**EMERGENCY CONTACT PHONE NUMBER(S):** \_\_\_\_\_

**LIST THE MEDICATIONS YOU TAKE** *(include dosage, amount and purpose- attach separate sheet if necessary)* :

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|  |  |
|--|--|
| <b>SUPPORT PERSON'S NAME<br/>(AT CONFERENCE) :</b>   |  |
| <b>WHAT KIND OF<br/>ASSISTANCE WILL YOUR<br/>SUPPORT PERSON<br/>PROVIDE?</b>                 |  |
|  |  |
|  |  |
| <b>DO YOU HAVE SEIZURES?</b><br><br><input type="checkbox"/> No <input type="checkbox"/> Yes | <i>(If yes, please describe the type of seizures, frequency, any intervention which should be done immediately after a seizure, and whether you have ever required hospitalization for a seizure)</i><br>_____<br>_____<br>_____ |
| <b>PLEASE LIST ANY OTHER<br/>MEDICAL ISSUES YOU HAVE</b>                                     |  |
|  |  |
|  |  |
|  |  |